



South Dakota Board of Nursing
 Unlicensed Assistive Personnel
 4305 South Louise Avenue Suite 201
 Sioux Falls SD 57106-3115
 (605) 362-2760 Fax: (605) 362-2768

Unlicensed Medication Aide (UMA) Renewal Application

****Allow up to 5-7 business days for the SDBON to process your application****

To renew registration, the Medication Aide shall submit verification of:

- A minimum of 12 hours of employment as an unlicensed medication aide within the last 2 years, as required in [20:48:16:03](#).

An incomplete form will result in denial of registration renewal.

Name: First: _____ Middle: _____ Last: _____

Other names previously used: _____

Registry #: _____ **Expiration Date:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone: Home: () _____ Cell: () _____ Other: () _____

Email: _____ **Date of Birth:** _____

Social Security #: _____ **Gender:** ☐ Male ☐ Female

Ethnicity: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other

Disciplinary Information:

Please provide details and/or documentation to explain each question with a "yes" answer. Attach additional pages to the application if needed. If further information is required, you will be notified by the South Dakota Board of Nursing.

1.	Have you been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations that have not previously been reported to the South Dakota Board of Nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Is there any pending criminal prosecution against you which would constitute a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have you had action taken against you for abuse, neglect, or misappropriation of property by a state or federal agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Are you currently being investigated or is disciplinary action pending against any license(s) or certificate(s) held by you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Has any license or certificate held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Have you been treated for abuse or misuse of any alcohol or chemical substance since your last renewal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Do you currently owe child support arrearages in the amount of \$1,000 or more?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



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This Section To Be Completed By Medication Aide Applicant

☐ YES ☐ NO I have been employed as an unlicensed medication aide within the last 2 years for at least 12 hours.

☐ YES ☐ NO Do you have a record of abuse, neglect, misappropriation, or is there any pending action?

*I declare and affirm that, to the best of my knowledge and belief,
all of the information provided on this application is complete, true, and correct.*

UMA Signature: _____ Date: _____

Employment Verification – This Section To Be Completed By Employer

Dates of Employment: From: _____ To: _____ (If presently employed, use “present”)

Total number of hours worked during this period: _____

☐ YES ☐ NO Does this applicant have a record of abuse, neglect, or misappropriation, or is there any pending action?

☐ YES ☐ NO I affirm that, to the best of my knowledge, all information provided on this verification is complete, true, and correct.

An incomplete form will result in denial of registration renewal.

Employer: _____

Address: _____

City, ST, Zip: _____

Telephone: _____ Date: _____

Employer Representative Signature/Title: _____

Send this completed application to the fax number listed above or email to Ashley.Vis@state.sd.us